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# Factitious Simulation of Systemic Lupus Erythematosus

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SELF-INFLICTED INJURIES AND DISEASES have been recognized since Biblical times. In the Middle Ages, hysterics were known to place leeches in their mouths to simulate hemoptysis and to abrade their skin to reproduce skin conditions.[1] Gavin in 1843 distinguished between malingering—feigning illness for financial compensation—and simulating illness for inexplicable motives.[2] In 1951 Asher identified the latter syndrome, naming it after the 18th century German nobleman with a predilection towards embellishment: Baron Karl Friederich Hieronymus von Münchausen.[3]

Munchausen syndrome is a variant of chronic factitious illness in which a patient's plausible presentation (often emergent and dramatic) of factitious symptoms and disease is associated with many hospital admissions.[4] Although this condition is thought to be rare, its presentation is not uncommon as persons with the syndrome drift from hospital to hospital, often with more than one admission at each. Invasive diagnostic studies and surgical procedures are common in these patients. Since the original description of this syndrome, many reports have documented the spectrum of disorders that have been simulated. We have not, however, seen any reports of a man with simulated systemic lupus erythematosus.

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## Report of a Case

The patient, a 29-year-old man with a history of systemic lupus erythematosus (SLE), was seen at the emergency department of the University of Utah Medical Center (Salt Lake City) because for eight days he had had right flank pain radiating to his right groin, nausea, vomiting, and gross hematuria. He had been seen at another facility where he was diagnosed with a kidney stone and treated with narcotics and intravenous hydration. Although he said he was "violently" allergic to intravenous contrast dye, the patient brought with him an intravenous pyelogram. He was seen in the urology clinic where his pyelogram was interpreted as normal without any signs of renal stones. He was then admitted for the evaluation of possible lupus nephritis.

The patient said he had been diagnosed with lupus five years ago at an unrecalled hospital. He said his symptoms at that time were "bursitic arthralgias," myalgias, low leukocyte count, photosensitivity (described as a rash on his arms and legs after sun exposure longer than 20 minutes), photophobia, pleuritic chest pain, a positive antinuclear antibody test, and a malar rash. In addition, the patient described "blackouts," which he presumed to be some type of seizure, that occurred from once a week to once a month, were preceded by a feeling of dizziness, lasted for several seconds, and were followed by disorientation for several hours. He never lost consciousness and did not have any incontinence during these episodes; none of them had ever been witnessed. He said he had a previous electroencephalogram at an unknown facility with unknown results. The patient also gave a history of a positive human immunodeficiency virus (HIV) test five years before, previous hepatitis, and previous nephrolithiasis.

On examination, the patient's vital signs were stable and he was afebrile. He appeared to be resting comfortably and conversed easily, often requesting medication to relieve the pain in his back. Any palpation of the patient was met with groans and exclamations of distress. His discomfort seemed to be greatest at the right costovertebral angle with considerable tenderness throughout his back and extremities. He had no lymphadenopathy or rashes. His cardiovascular system was normal, and his lungs were clear to auscultation. The chest pain was reproducible with sternal pressure. His abdomen was tender to palpation in the right upper and lower quadrants. The results of his neurologic examination were within normal limits without any focal signs, and extremities were remarkable only for several areas of hypopigmentation on his upper extremities and multiple punctate lesions on the pad of his left index finger.

Laboratory data showed a leukocyte count elevated at 10.7 cells $\times 10^9$ per liter (10,700 cells per mm$^3$) with a normal differential cell count, a hematocrit of 0.41 (41%), a platelet count of 211 $\times 10^9$ per liter (211,000 per mm$^3$), normal electrolytes, normal liver function test results, and a sedimentation rate of 2 mm per hour. On analysis the urine was "cloudy" with a specific gravity of 1.020, a pH of 7.0, without protein, nitrate, or ketones, and without leukocytes or casts. There were 10 to 20 erythrocytes vis-

**ABBREVIATIONS USED IN TEXT**

HIV = human immunodeficiency virus
SLE = systemic lupus erythematosus

ible per high-power field; they were not crenated. The antinuclear antibody test was negative, and serum levels of complement components C3 and C4 were normal. The rapid plasma reagin test was nonreactive, and a test for the hepatitis B core antibody was positive. His chest film showed low lung volumes, linear atelectasis, poor inspiratory effort, and a heart size at the upper limits of normal.

The patient was admitted late in the afternoon and given meperidine hydrochloride, 25 mg intravenously every four to six hours for pain, with subsequent full workup done the following day. During this evaluation he said that he had never had a malar rash and had a second HIV test a month before that was negative. He said that he had been admitted to a hospital in San Francisco, California, in Colorado, and in various places in Utah but could not provide the names of any of these hospitals. In addition, he gave the name of a local physician as his primary care physician but said that she would no longer see him as he could not afford to pay his bills. The nephrology service was consulted and recommended a kidney biopsy, providing the rest of his workup was consistent with SLE. Later that day the patient's former physician was contacted and reported that the patient had an extensive history of presenting to emergency departments with flank pain, hematuria, and an alleged allergy to intravenous contrast dye, frequently obtaining narcotic analgesia, and occasionally being admitted to the hospital. She thought that his hematuria was factitious from self-inflicted puncture wounds. In addition, he was HIV negative by a test done in her office within the previous three months. She had terminated their physician-patient relationship because she specializes in the treatment of HIV-positive patients and she felt he had a psychiatric illness that she was not qualified to treat. He had refused her many referrals for psychiatric evaluation and treatment.

This information was discussed with the patient, who vehemently denied any past psychiatric referrals or previous episodes of hematuria. When asked how he received the pinpricks to his left index finger, he said that he got them from "painting." The patient was asked if he would produce an observed urine specimen to test for blood, which he declined to do. He was offered referral to the psychiatric service but elected to be discharged with outpatient follow-up with the psychiatric and rheumatology services. He did not keep either appointment.

## Comments

The classic features of the Munchausen syndrome are as follows: a socially isolated young adult, pathologic lying, numerous appearances at many hospitals, dramatically feigned severe illness of an acute and harrowing nature, factitious evidence of disease, a medically informed or convincing background history, history of several surgical procedures, evasiveness in manner, frequently a tendency to drug addiction, indignant departures from hospitals against medical advice when discovery has occurred or seems imminent, a failure to report for follow-up appointments, and the absence of any readily discernible ulterior motive.[1,3,5-7] The full spectrum of features may not appear until late in the course of this syndrome.[6]

A great many disorders have been mimicked, limited only by the creativity of the patient. Cases of feigned Goodpasture's syndrome[1]; small bowel obstruction, hematemesis, and peptic ulcer disease[3]; sickle cell anemia and crisis[5]; seizures or neurologic manifestations[8]; renal lithiasis[9,10]; asthma, fever, and Bartter's syndrome[11,12]; systemic lupus erythematosus[11,13]; abdominal pain, emesis, cardiac complaints, and dermal conditions[8]; migraine headaches, chronic dislocating shoulder, tic douloureux, and abscessed teeth[10]; and diarrhea, urinary tract infection, meningitis, hyposthenuria, hyperthyroidism and hypothyroidism, and extremity lymphedema[12] have all been reported.

In systemic lupus erythematosus, 11 criteria have been designated for classification, with the presence of 4 criteria, either serially or simultaneously, required for diagnosis.[14] Our patient had, by history, 8 of the 11 criteria. His complaints of photosensitivity did not involve all sun-exposed areas. His claimed malar rash and arthritis were unsubstantiated by physical examination. His complaint of pleuritic chest pain was convincing, but he had no pericardial friction rub, pleural effusion, or other objective evidence of serositis. His renal symptoms, without proteinuria or casts and with noncrenated erythrocytes, are almost certainly a factitious addition of blood to his urine specimens. The patient was neurologically intact, and his history is inconsistent for the generalized tonic-clonic seizures classically seen in SLE. The patient had neither anemia, leukopenia, lymphopenia, nor thrombocytopenia. He was nonreactive for rapid plasma reagin, and his antinuclear antibody test was negative. His method of falsifying hematuria by adding blood from self-inflicted needle sticks is not unique.[4,5,8,10-13,15] It is of interest that the patient is right-handed. As Shafer and Shafer noted: "Factitious lesions are rarely seen on the right hand or wrist of a right-handed person or on the left hand or wrist of a left-handed person."[12(p597)] Therefore, it would be prudent for a physician suspecting Munchausen or any other factitious syndrome to search the nondominant extremity for possible signs of injury.

We initially suspected this patient of being addicted to narcotics. Although narcotic use (especially meperidine) and addiction can be a facet in Munchausen's,[1,3-10,12,13,15-17] these patients do not have withdrawal symptoms on stopping the drug, nor is obtaining drugs the goal of their admission to hospital.[6,8,10] If our patient's goal was to obtain narcotics, he could have avoided an intravenous pyelogram and continued his excursions to various emergency departments, receiving narcotics for the outpatient treatment of a presumptive kidney stone.

The appropriate treatment is intensive psychiatric therapy. Unfortunately, patients with the Munchausen syndrome are resistant, with few recorded "cures."[17] The best

treatment is early recognition. Antipathy at being deceived by these patients is understandable. Beguiled physicians should realize, however, that although this disorder is "voluntary" in the sense that patients know they are pretending, they are unable to stop. Rather, they deceive themselves with their own fabrication. Moreover, physicians need to be the patients' advocates in deciding on appropriate therapy. Only in this way can unnecessary operations and invasive diagnostic studies, with their inherent risks of complications, be avoided and the correct treatment be attempted. In addition to the risk of iatrogenic injury, the time and expense saved by rapid recognition, especially in view of limited health resources, may be the greatest benefit.


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# Black Widow Spider (*Latrodectus mactans*) Bite During Pregnancy


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SPIDERS OF THE GENUS *Latrodectus* are found in all parts of the United States and throughout the world. They are common in the southwestern states and are found in and around domestic areas. Bites are not uncommon despite the docile nature of spiders—they seem to bite only when provoked. Information about spider bites and envenomation during pregnancy is lacking, but pregnancy does not protect a woman from this type of accident.[1,2] We present a case of latrodectism occurring in a pregnant woman and discuss the literature of black widow spider bites during pregnancy.

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## Report of a Case

The patient, a 36-year-old woman at 22 weeks' gestation, was admitted to the University of New Mexico Hospital/Bernalillo County Medical Center (Albuquerque) because of restlessness, pain and cramping in her legs, hips, and lower back, shortness of breath, and chest tightness. She had been bitten on her upper left thigh while in bed. The patient found a spider in the bedsheets that she killed and brought with her to the hospital. It was identified as a "black widow" spider. The patient did not have uterine cramping, vaginal bleeding, or rupture of membranes.

On physical examination the patient had a temperature of 37.3°C, a blood pressure of 156/81 mm of mercury, a pulse rate of 92 beats per minute, and a respiratory rate of 16 per minute. She was alert and oriented but appeared anxious. The examination elicited no abnormalities except that her upper left thigh had about a 2-mm erythematous papule on the lateral aspect. The deep tendon reflexes were normal. Her cervix was closed, long, and high, and no vaginal bleeding was noted. Ultrasonography revealed a single live fetus, the size of which was consistent with dates. Laboratory studies revealed a leukocyte count of $10.9 \times 10^9$ per liter (10,890 per $mm^3$) with 0.82 (82%) neutrophils.

The patient was initially given 10 ml of a 10% solution of calcium gluconate, 5 mg of diazepam, and 5 mg of morphine sulfate. She experienced some relief, but the muscle cramping and pain soon returned. She was given another 10-ml dose of a 10% solution of calcium gluconate and 5 mg of morphine sulfate. A skin test was done of the antivenin, and a standard dose—one 2.5-ml vial of antivenin in 50 ml of normal saline solution—was administered intravenously over 15 minutes. Within an hour of the administration of the antivenin, the patient indicated that she did not have any muscle cramping or pain, and she no longer appeared anxious. She was discharged the following day in good condition.

## Discussion

The genus *Latrodectus* comprises several species. *Latrodectus mactans* (black widow), *Latrodectus geometricus* (brown widow), *Latrodectus bishopi* (red-legged widow), *Latrodectus variolus*, and *Latrodectus hesperus* are the species found in North America. Although they differ in their markings and color, their potent neurotoxins are similar and respond to the same antivenin. Generally speaking, only the female spider is considered a threat to humans. The male's small size and small che-